

## **Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Annual Report (AR)**

These instructions were developed to assist Local Educational Agencies (LEAs) in completing the LEA Medi-Cal Billing Option Program Provider Participation Agreement (PPA) and Annual Report (AR).

The AR includes the LEA Medi-Cal Provider Enrollment Information Sheet, LEA Consortium Billing Sheet, Certification of State Matching Funds for LEA Services, Annual Report Financial Statement Data, and the Statement of Commitment to Reinvest. The PPA and AR are used to enroll LEAs in the LEA Medi-Cal Billing Option Program.

- DO NOT revise the forms as they are considered a legally binding contract.
- This is a fillable document; all information must be typed, except where specifically noted.
- Print the instructions and use them to help you navigate through tabs at the bottom of the page to assist with the completion of the Annual Report.

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### **PAGE 1: LEA MEDI-CAL PROVIDER ENROLLMENT INFORMATION SHEET**

**Date:** Enter the date.

**Official LEA Name:** Enter the official name of your LEA as registered with California's Department of Education.

- **Note:** This field will auto populate throughout the document.

**Doing Business As (DBA):** Enter the business name of your LEA if it differs from the Official LEA Name used for tax purposes on file with the IRS.

- The business name should be listed as a DBA name on the Medi-Cal Provider Master File; however, the LEA name that is on file with the Department of Education is the Official LEA Name.

**Check All that Apply:** Check all of the appropriate boxes that apply to your LEA.

- Consortium Billing: If your LEA is a billing consortium, where several other LEAs bill under your LEA's NPI, check this box and complete the requested LEA information on the consortium billing page.
- Update LEA Name: If the Official LEA Name has changed, check this box and type the correct Official LEA Name in the designated field. **If you update the Official LEA Name, you will need to submit a complete signed PPA.**

**LEA Administrative Office Address:** Enter the address from which your LEA will be preparing Medi-Cal claims and will maintain the Medi-Cal documentation related to the claims.

- DO NOT use a post office box address.

**Payment/Mailing Address:** Enter the address to which your LEA will receive payment. Select "Same as Above" if it is the same as the Administrative Office Address.

**LEA Primary Contact Information:** Enter the name, title, phone number and email of the person within the LEA responsible for administering the LEA Medi-Cal Billing Option Program.

**LEA Secondary Contact Information:** Enter the name and email of the person within the LEA who assists with administering the LEA Medi-Cal Billing Option Program.

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**Billing Vendor/Billing Agent Information:** Enter the company, and name, phone number and email of the Vendor/Billing Agent contact person responsible for the LEA Medi-Cal Billing Option Program.

**California School Directory (CDS) Code:** Enter the 14-digit California School Directory (CDS) Code as registered with the Department of Education.

- This information can be found in the [CDS Directory](#).

**National Provider Identification (NPI) Number:** Enter your LEA's unique 10-digit NPI number.

- **Note:** This number will auto populate throughout the document.

The NPI Number is issued and obtained through the Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES). If you have not already obtained an NPI Number, you must obtain one prior to applying to participate in the LEA Medi-Cal Billing Option Program.

- Information on the web: [CMS Website](#)
- Information via the NPI Enumerator Phone Line: 1-800-465-3203
- Applying on the web: [NPPES Website](#)

**LEA Federal Employer Identification Number (EIN):** Enter the nine (9) digit LEA Federal Employer Identification Number (EIN) on record with the IRS. It is imperative that the Official LEA Name and Federal EIN number are in accordance with the LEA's IRS records. Your Business Service/Fiscal Officer can provide the required IRS documentation that must accompany your enrollment application.

- Check with your Business Service/Fiscal Officer to ensure that the EIN provided is not shared with a County Office of Education, Superintendent of Schools, or SELPA.

**Signature of Authorized Representative:** An authorized representative is a person who has the authority to bind the LEA to the statements made on the LEA Medi-Cal Provider Participation Agreement, whose signature certifies that the information provided is true, accurate, and complete. The Superintendent, Assistant Superintendent or Authorized Business Services/Fiscal Officer must sign in blue ink.

**Name and Title of Authorized Representative:** Enter the name and title of the person who signed the LEA Medi-Cal Provider Enrollment Information Sheet.

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### PAGE 2: LEA CONSORTIUM BILLING

This form is only required if the LEA is part of a billing consortium where more than one LEA bills under your LEA's NPI number.

- Include all LEAs claiming under the same NPI on this sheet.
- Do not include each school within a district, county, etc.
- **Note:** The LEA that is directly linked to the NPI is responsible for making sure that the funds for all LEAs in the consortium are included in the annual report.

**LEA Name:** Enter the LEA name as registered with the Department of Education for each LEA in the consortium.

**CDS Code:** Enter the 14-digit CDS code for each LEA in the consortium.

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**LEA District:** Enter the school district the LEA is located in, if it is different from the claiming LEA.

- This information can be found in the CDS Directory

**Charter:** Enter 'Yes' or 'No' if the LEA is a charter school.

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### PAGE 3 - ATTACHMENT 1: CERTIFICATION OF STATE MATCHING FUNDS FOR LEA SERVICES

**Budgeted Line:** Enter the amount your LEA has budgeted in the current fiscal year to fund the activities covered by the LEA Medi-Cal Billing Option Program. This line must include a dollar figure greater than \$0.

- **Note:** To estimate the dollar amount to include on the Certification of State Matching Funds for LEA Services, add up the costs of employees who provide health services (wages, benefits, administrative costs), and any contracted health services. (Exclude any employees who are 100% federally funded from the calculation, but include all other nurses, counselors, psychologists, etc.)

**Signature of Authorized Representative:** The person who has the authority to bind the LEA to the statements made on the Certification of State Matching Funds for LEA Services (Attachment 1) and whose signature certifies that the information provided is true, accurate, and complete must sign this form in **blue ink**. This should be the Superintendent, Assistant Superintendent, or Business Services/Fiscal Officer.

**Name of the Authorized Representative:** Enter the name of the person who signed the Certification of State Matching Funds for LEA Services.

**Title of the Authorized Representative:** Enter the title of the person who signed the Certification of State Matching Funds for LEA Services.

**Date:** Enter the signature date.

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### PAGE 4 - ATTACHMENT 1A: FINANCIAL STATEMENT DATA FOR PRIOR YEAR CLAIMING

Financial Statement July 1, 2018 – June 30, 2019: Summarize revenues received, if any, from the LEA Medi-Cal Billing Option Program during the prior fiscal year for which you are reporting and list how your LEA has reinvested those revenues in expanded health and social services.

**Line (a):** Enter the total LEA revenue received from the LEA Medi-Cal Billing Option Program for the 2018-19 fiscal year.

**Line (b):** Enter the total LEA revenue carried over from the LEA Medi-Cal Billing Option Program from previous fiscal year(s). This should be a positive number.

**Reinvestment Expenditures:** Using the check-boxes on the document, list your LEA's reinvestment of its unexpended revenue. This may be similar to the anticipated service priorities for the next fiscal year. The plan for future use of unexpended revenue may also be based on anticipated service priorities decided by the LEA Collaborative for the reporting fiscal year.

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### PAGE 5 - ATTACHMENT 2: STATEMENT OF COMMITMENT TO REINVEST FOR CURRENT YEAR CLAIMING

The LEA Collaborative makes decisions regarding the reinvestment of LEA Medi-Cal Billing Option Program funds.

**Description of LEA Medi-Cal Collaborative:** Describe the role of the collaborative by answering how reinvestment decisions are made, and the planned frequency of meeting.

- **Note:** If the collaborative has not yet developed an infrastructure, please do so in order to answer these required questions. Leaving this area blank or answering “not applicable” is not an acceptable response.

**Anticipated Service Funding Priorities:** List the top service funding priorities for your LEA for the upcoming school year.

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### PAGE 6 - ATTACHMENT 2A: STATEMENT OF COMMITMENT TO REINVEST (LEA INTERAGENCY COLLABORATIVE PARTNERS)

**Names/Titles of the Collaborative Partners:** Enter the name and title of the persons who signed the Statement of Commitment to Reinvest, and all others who are part of the LEA Collaborative.

**Organizations of the Collaborative Partners:** Enter the affiliated organizations of the persons who signed the Statement of Commitment to Reinvest, and all others who are part of the LEA Collaborative.

**Signatures of the Collaborative Partners:** The persons who have the authority to bind the LEA to the statements made on the Statement of Commitment to Reinvest (Attachment 2A) must sign this form, and all others who are part of the LEA Collaborative.

- ALL LEA Collaborative partners are required to provide signatures on this document in **blue ink**.

**Date:** Enter the signature date.

# Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Annual Report (AR)

## SUBMISSION INSTRUCTIONS

Submit the AR to DHCS by one of three ways:

(1) Complete the AR online using electronic signatures and email as a PDF file.

(2) Complete the AR online and print, hand sign, scan and email as a PDF file.

- For options (1) and (2), save the file using the following naming convention on the document and in the subject line: *2019.AR.LEA Name.NPI Number.pdf*
- Example: *2019.AR.NewHaven.1987654321.pdf*
- For options (1) and (2), email the documents to [LEA.AnnualReport@dhcs.ca.gov](mailto:LEA.AnnualReport@dhcs.ca.gov)

(3) Complete the AR online and print, sign **(blue ink)** and mail a hard copy, **including a signed copy of the PPA (if new LEA)** to:

Department of Health Care Services  
Safety Net Financing Division  
LEA Program Unit  
1501 Capitol Avenue, MS 4603  
Sacramento, CA 95899-7436